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F 000	INITIAL COMMENTS The following citations represent the findings of the health resurvey of this facility.	F 000		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: The facility reported a census of 38 residents. The sample of 16 residents included 3 reviewed for activities. Based on observation, interview, and record review, the facility failed to provide an ongoing activity program for 1 (#12) of the 3 residents reviewed for activities. Findings included: - Resident #12 ' s admission record documented the resident admitted on 9/25/09, with the following diagnoses including; dementia (progressive mental disorder characterized by failing memory, confusion), and macular degeneration of the retina (progressive deterioration of the retina). The Annual MDS (minimum data set), dated 10/14/14, revealed the resident was unable to provide information, and the staff assessment revealed the resident enjoyed listening to music. The resident required total assistance with activities of daily living, and was not ambulatory.	F 248		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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The activity CAA (care area assessment), dated 10/17/15 revealed the resident was not able to communicate effectively. The family visited often and the resident enjoyed 1 to 1 conversation, and music.

The care plan, reviewed on 7/29/15, revealed the resident preferred to participate in group activities, and the resident ' s specific individual activity preference was visits, aromatherapy, music, and 4th grade readers. Staff would complete an activity assessment at least annually to determine interests, taking into consideration of physical and/or mental limitations. Staff would invite the resident to activities, and assist the resident to participate during the activities.

The activity assessment, dated 7/23/15, revealed the resident napped regularly during the day. The resident ' s current interests were music, parties, social events, radio, reading, spiritual, grooming, outdoors, television, conversing, volunteer visits, and resident visits.

Review of the activity progress notes from 6/9/15 to 9/30/15 revealed the resident attended an activity only 6 times during the time frame reviewed.

On 9/29/15 at 1:40 PM, the resident remained in his/her room. Observation revealed the room lacked a radio, music, or a television.

On 9/29/2015 at 1:34 PM, direct care staff I, stated the resident did not go to many activities, and stated he/she used to have a soothing music player, and verified the music box was now unavailable in the resident ' s room.

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F 248	Continued From page 2 On 9/29/2015 at 5:40 PM, activity staff BB, stated the resident would listen to a sound machine, but the sound machine was no longer in his/her room, and did not know what the resident ' s activity preferences were currently. On 9/30/2015 at 11:33 AM, social service staff D, stated the resident had a sound machine in his/her room, but it was now kept in the activity department, and explained there was no available radio to keep the resident ' s room at this time. On 9/30/2015 at 2:18 PM, direct care staff J, stated the resident did enjoy music, and would attend some music programs, but the resident did not attend card playing. Direct care staff J stated there was nothing in the resident ' s room for activities for the resident. On 9/30/2015 at 3:49 PM, administrative nursing staff C, stated staff would put a sound machine in his/her room for activity, and staff used to take him/her to cards, but the resident was unable to participate in any activities. The facility lacked a policy for activities for the cognitively impaired, dependent residents of the facility. The facility failed to provide an ongoing activity program for this cognitively impaired resident, to enhance the resident ' s highest level of physical, mental, and psychosocial well- being.	F 248		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive	F 274		

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assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 38 residents, with 16 selected for review. Based on observation, interview and record review, the facility failed to assess 2 residents (#38 and # 2) for significant change in status.

Findings included:

- Resident #38's physician order sheet, dated 9-8-15, included diagnoses of dementia (progressive mental disorder characterized by failing memory and confusion) with unspecified psychosis (any major mental disorder characterized by a gross impairment in reality testing), peptic ulcer disease, esophageal reflux (backflow of stomach contents to the esophagus), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

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Review of the resident's medical record, revealed the resident transferred to acute care on 8-21-15 and returned to the facility on 9-8-15.

The admission MDS (minimum data set) dated 8-21-15 assessed the resident with severe cognitive impairment, with fluctuating times of inattention and disorganized thinking. He/she had wandering behavior, required extensive assistance with dressing and toilet use, limited assistance with bed mobility, transfer, walking, eating, and personal hygiene, and was always continent of bowel and bladder. The resident required limited assistance to eat and did not have swallowing or dental problems. The record documented a height of 60 inches and current weight of 139 pounds without or unknown weight loss. The resident received antidepressant medications daily and 1 day of antianxiety medication during the 7-day observation period.

The Nutrition CAA (care area assessment) dated 8-21-15 advised staff the resident received a regular diet and could feed him/herself.

The care plan dated 9-10-15 instructed staff the resident needed assistance at mealtimes and could feed him/herself at times. The care plan advised staff the resident was totally incontinent of bowel and bladder, and needed staff to reposition the resident in bed every 2 hours. It directed staff the resident could ambulate with assistance of one staff and a gait belt for short distances and staff needed to propel the resident in his/her wheelchair.

Observation revealed on 9-29-15 at 8:42 a.m. direct care staff B, sat down beside the resident

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and assisted the resident to eat. The resident drank 540 cc (cubic centimeters) of fluid with episodes of coughing after swallowing, and a few bites of fruit loops. The resident attempted to hold a glass of water, but could not to bring the glass to his/her mouth, at which time staff B obtained a straw for the resident. Interview at that time with staff B revealed the resident required staff assistance with eating could no longer walk.

Observation, on 9-29-15 at 12:29 p.m. revealed direct care staff T and direct care staff U took the resident away from the dining table to use the bathroom. The resident was incontinent of urine and started to have a bowel movement in the incontinence brief.

Interview on 9-29-15 at 12:30 p.m. with direct care staff T revealed the resident was incontinent of bowel and bladder.

Interview on 9-30-15 at 3:30 p.m. with administrative staff C revealed the resident did decline in several areas of daily living and staff should have completed a significant change MDS.

The facility lacked a policy to assess the resident for significant change.

The facility failed to complete a significant change MDS assessment when resident #38 declined in activities of daily living.

- Review of resident #2's signed admission orders dated 5/28/15 revealed the following

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diagnoses: dementia (progressive mental disorder characterized by failing memory and confusion), coronary artery disease (CAD-abnormal condition that may affect the flow of oxygen to the heart), chronic pain, and chronic urinary tract infection (UTI).

Review of resident #2's comprehensive MDS (minimum data set) assessment dated 6/5/15 revealed he/she had a BIMS (brief interview for mental status) of zero, indicating severe cognitive impairment. The resident did not have any communication difficulties. He/she exhibited no behaviors or delirium and required supervision of one staff for transfers and walking in and out of his/her room. Further review revealed he/she required extensive assistance of one staff for toilet use. He/she had occasional bladder incontinence and staff used a bladder training program.

Review of the Dementia CAA (care area assessment) dated 6/5/15 revealed resident #2 had short and long-term memory loss with confusion and depended upon staff for ADL (activities of daily living) cares.

Review of resident #2's Urinary Incontinence CAA dated 6/5/15 revealed at times he/she could alert staff he/she needed to use the bathroom. Further review revealed he/she did not alert anyone after he/she had incontinence. He/she did not remember to change his/her adult incontinent product if he/she had incontinence and did not provide hygiene for him/herself, or even remember where bathroom was. Further review revealed care plan interventions were in effect to decrease his/her incontinence.

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Review of the 6/2/15 care plan for resident #2 revealed staff were to ensure he/she did not have to go to the bathroom before assisted to activities. Further review revealed resident #2 wanted to be continent of bladder and bowel but could not toilet him/herself, therefore staff were to offer to toilet the resident. The care plan revealed resident #2 used incontinent products to keep him/her as dry as possible and odor free. Staff were to assist him/her with toileting needs, provide hygiene needs after each incontinent episode, to help him/her clean him/herself each shift and when he/she had a bowel/bladder accident, and to assist with changing his/her pads. Further review reveled staff were to monitor and document all bowel movements, to assist resident #2 to the toilet every 2 hours during the day, before and after meals, 3-4 times at night, and provide 1-2 staff assist with hygiene and toileting.

Review of resident #2's quarterly MDS dated 9/15/15 revealed no change in the resident ' s cognition, ability to communicate, behaviors, or ADL (activities of daily living) and he/she always had bladder incontinence.

Review of the nurse physician report dated 8/12/15 revealed staff reported the resident had been exhibiting increased confusion, episodes of crying, and combative behaviors. Further review revealed the resident had refused to eat anything for breakfast, very little for lunch, and did not drink adequate fluid.
Review of the nurse physician report dated 8/21/15 revealed staff reported the resident had difficulty swallowing pills.
Review of the nurse physician report dated 9/16/15 revealed staff reported the resident was eating poorly and staff requested a pureed diet

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for him/her.

Review of the nurse physician report dated 9/22/15 revealed staff reported the resident had exhibited rigidity and had difficulty bending to sit down. Staff further reported due to rigidity the staff placed the resident in a hight back wheelchair.

Observation on 9/29/15 from 7:20 AM until 9:37 AM revealed resident remained seated in his/her wheelchair in the dining room. At 9:37 AM direct care staff AA propelled him/her to the restroom in the activity room and provided gait belt assist to transfer the resident to the toilet. Direct care staff T prompted him/her to urinate and he/she did, without any obvious problems. Staff T provided appropriate hygiene care and resident #2's buttocks looked normal without any areas of redness. The brief staff removed from the resident remained dry.

Observation on 9/29/15 at 4:02 PM revealed direct care staff U and direct care staff T assisted resident #2 to the restroom in his/her wheelchair and provided a gait belt assisted transfer to the toilet where the resident urinated upon prompting by staff. Further observation revealed staff removed a dry adult incontinent brief from the resident.

During an interview on 9/30/15 at 11:34 AM direct care staff B reported resident #2 had a general decline since admission. Staff B further reported the facility did not have a system in place to assess the cause for the incontinence, monitor for the incontinence pattern, and/or develop individualized toileting plans for incontinent residents of the special care unit (SCU) to

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maintain as much normal bladder function as possible. Staff B further reported the facility previously had a process in place, but approximately 18 months ago, the facility stopped using it. Staff B reported voiding assessments should be completed every year for residents.

During an interview on 9/30/15 at 3:39 PM, direct care staff P reported resident #2 had been difficult to understand and that he/she needed to be toileted every 2 hours. Staff P further reported the resident had a dry brief most of the time with one wet brief per his/her shift. Staff P further stated resident #2 voided when prompted.

During an interview on 9/30/15 at 4:05 PM, direct care staff H reported resident #2's incontinence had worsened since his/her shingles diagnosis (9/3/15) and he/she declined. Staff H reported resident #2 did not talk much, but urinated if prompted. Staff H reported the resident had more incontinent episodes when he/she had pain. Staff H further reported the resident had a lot of pain after his/her tooth extraction (6/11/15) and stopped talking after that time. Staff H stated he/she reported all declines in ADLs to the nurse.

During an interview on 9/30/15 at 4:29 PM licensed nursing staff R reported resident #2 had incontinence but used the toilet more before shingles. Staff R further reported resident #2 had mouth pain and required a soft diet. Staff R reported staff assisted him/her to the restroom every 2-3 hours, before supper, and before bed.

During an interview on 9/30/15 at 5:02 PM Administrative staff C reported resident #2's status had changed a lot since arriving at the SCU. Staff C reported the resident had weight

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F 274	Continued From page 10 loss, UTIs, and teeth extracted and verified a significant change did occur. Staff C verified a significant change assessment should have been completed. Review of the RAI manual revealed a significant change (either decline or improvement) in a residents condition from his/her baseline that occurred, as indicated by comparison of the resident's current status to most recent comprehensive assessment and any recent quarterly assessment and the resident's condition is not expected to return to baseline for two weeks, indicated a significant change assessment should be completed. The facility failed to conduct a significant change MDS asessment after a decline in 2 or more areas of the residents physical functioning for resident #2.	F 274		
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: The facility census totaled 38 residents with, 16 included in the sample. Based on interview and record review, the facility failed to ensure staff completed a quarterly MDS (minimum data set) assessment for 1 of 5 residents reviewed for unnecessary medications. (#28)	F 276		

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Findings included:

- Review of resident #28 ' s quarterly MDS (minimum data set) dated 1/13/15, revealed he/she had a BIMS (brief interview for mental stats) of 0, indicating severe cognitive impairment. He/she exhibited no signs of delirium or behaviors. The resident was independent with bed mobility, transfers, and walking in the room and corridor. The resident received daily antidepressant medication and 3 days of antibiotics during the 7-day observation period.

Review of resident #28 ' s annual MDS dated 7/16/15, revealed he/she had no change in cognition, behaviors, or ADL (activities of daily living) ability from the previous assessment on 1/13/15. Resident #28 received antipsychotic and antidepressant medications daily during the 7-day observation period.

Review of the resident ' s MDS record from 1/13/15-7/16/15 revealed no quarterly assessments were completed between the two assessments.

Interview with administrative nurse C, on 10/1/15 at 9:22 AM, revealed he/she had the responsibility for completing MDS assessments for the facility, around April, 2015, at the time the quarterly MDS needed completed. Staff C reported he/she did not realize he/she missed completing a quarterly MDS on time, when he/she went in to complete the annual assessment in July 2015.

According to the RAI (Resident Assessment Instrument) Manual 3.0, quarterly MDS assessments must be completed within 92 days

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F 276	Continued From page 12 of the previous assessment. The facility failed to ensure staff completed a quarterly assessment when due in April, 2015, for resident #28.	F 276		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: The facility reported a census of 38 residents, with 16 selected for review. Based on observation, interview and record review, the facility failed to review and revise the plan of care for grooming and bathing for 1 (#26) of the 16 residents reviewed.	F 280		

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Findings included:

- Review of resident # 26's annual MDS (minimum data set), dated 11-13-14, documented the resident as cognitively intact and needed assistance of 1 with bathing. The assessment indicated the resident felt it was very important to choose a tub bath or shower.

The CAA (care area assessment) for activities of daily living, dated 11-14-15, assessed the resident required assistance with showering and was able to make his/her needs and wants known, to make choices and go to bed when he/she desired.

The care plan, revised 8-12-15, advised staff the resident desired independence but needed staff cueing and physical assistance for activities of daily living, and lacked preferences for bathing and grooming.

Observation, on 9-28-15, at 11:08 am, revealed the resident with facial hair of several days growth.

Interview with the resident, on 9-28-15 at 11:08 am, revealed the resident received a shave when in the whirlpool, which was twice a week, but the resident desired to be shaved daily.

Observation, on 9-30-15 at 10:30 am, revealed the resident awake in the room, reclining in bed, and noted with several days of facial hair growth.

Interview, on 9-30-15 at 10:30 am, with the

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F 280	Continued From page 14 resident, revealed the resident felt the facial hair caused itching, and he/she would like to have it shaved. The resident stated he/she did make attempts to shave with the electric razor, but had difficulty getting close enough to get a smooth shave. The resident stated he/she was scheduled to receive a bath in the evenings, but staff became busy or he/she was outside and missed the baths and the assistance with shaving was also missed. Interview, on 9-30-15 at 3:30 pm, with administrative nursing staff C, revealed the resident stayed up late at night, and then slept in during the morning and was in and out of the facility until dusk, and thought the care plan should be revised to include the resident ' s habits, and change the bath time to late night. The facility lacked a policy on revision of the care plan. The facility failed to review and revise the bathing and grooming care plan to ensure the resident's preferences for daily shaving and bathing times were reviewed for resident preferences and daily schedule.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		

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This REQUIREMENT is not met as evidenced by:
The facility reported a census of 38 residents. The sample of 16 residents included 3 residents reviewed for skin condition. Based on observation, interview, and record review, the facility failed to monitor a bruise for 1 (# 31) of the 3 sampled residents.

Findings included:

- The electronic chart revealed resident # 31, admitted on 8/26/14, with the following diagnoses including; chronic obstructive asthma (chronic inflammatory disease of the airways characterized by variable and recurring symptoms, reversible airflow obstruction and bronchospasm) and edema (swelling resulting from an excessive accumulation of fluid in the body tissues).

The annual MDS (minimum data set) dated 9/2/15, revealed the resident had a BIMS (brief interview for mental status) score of 15, indicating intact cognition. The resident was independent with ADL's (activity of daily living), and was mobile with a wheelchair. The resident did not have skin issues and received an anticoagulant medication.

The CAA (care area assessment), dated 9/10/15, for ADL's revealed the resident was alert and oriented and independent in ADL's, and was aware of safety needs.

The care plan, reviewed on 6/2/15, guided staff to notify the physician of any unusual or unexpected

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bleeding, and to monitor the resident's skin integrity daily.

Review of the skin and wound report from 9/1 thru 29/15, lacked documentation of any bruising to the left arm.

On 9/28/15 at 11:38 am, observation revealed a deep blue discoloration to the resident's left forearm approximately 3 by 2 inches in diameter.

On 9/29/2015 at 1:24 PM,direct care staff I, stated the bruise occurred because he/she would run into the wall or the door frame with his/her scooter, because the resident did not slow down very well going through the doors.

On 9/29/2015 at 4:36 PM, the resident stated the bruise happened a few days ago when he/she went to get some coffee and brushed his/her arm on the door frame while backing out of the doorway. The resident stated a nurse checked his/her arm the other day, but could not remember which day.

On 9/30/2015 at 2:46 PM, licensed nursing staff K stated when a skin problem occurred, the nurse would measure the wound and document the findings in the skin and wound report and in the nurse progress note.

On 9/30/2015 at 3:22 PM, administrative nursing staff C, stated the nurse was expected to measure and document the skin injury and chart on the bruise daily until it was resolved. The physician and the family would be notified of skin injuries, and determine the appropriate interventions.

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F 309	Continued From page 17 Review of the facility's Prevention of Skin Breakdown policy, dated 4/2010, revealed staff should complete a skin integrity assessment on admission and weekly for 4 weeks, then quarterly, and with a significant change. The facility failed to monitor the resident's skin integrity daily, who had a bruise on his/her forearm.	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: The facility reported a census of 38 residents, with 16 selected for review. Based on observation, interview and record review, the facility failed to provide grooming and bathing assistance as often as desired for 1 (#26) of the 16 residents reviewed. Findings included: - Review of resident # 26's annual MDS (minimum data set), dated 11-13-14, documented the resident as cognitively intact and needed assistance of 1 with bathing. The assessment indicated the resident felt it was very important to choose a tub bath or shower. The CAA (care area assessment) for activities of	F 311		

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daily living, dated 11-14-15, assessed the resident required assistance with showering and was able to make his/her needs and wants know, able to make choices and go to bed when he/she desired.

The care plan, revised 8-12-15, advised staff the resident desired independence but needed staff cueing and physical assistance for activities of daily living.

Observation, on 9-28-15, at 11:08 am, revealed the resident with facial hair of several days growth.

Interview with the resident, on 9-28-15 at 11:08 am, revealed the resident received a shave when in the whirlpool, which was twice a week, but the resident desired to be shaved daily.

Observation, on 9-30-15 at 10:30 am, revealed the resident awake in the room, reclining in bed, and noted with several days of facial hair growth.

Interview, on 9-30-15 at 10:30 am, with the resident, revealed the resident felt the facial hair caused itching, and he/she would like to have it shaved. The resident stated he/she did make attempts to shave with the electric razor, but had difficulty getting close enough to get a smooth shave. The resident stated he/she was scheduled to receive a bath in the evenings, but staff was busy or he/she was outside and missed the baths and the assistance with shaving was missed.

Interview, on 9-30-15 at 10:46 am, with direct care staff I, revealed the evening shift provided the bathing for this resident, but if the resident

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F 311	Continued From page 19 wanted a shave, any staff could provide it. Interview, on 9-30-15 at 3:30 pm, with direct care staff Z, revealed the resident would go outside and then miss the bathing opportunity. Staff Z stated the resident did not receive the scheduled bath on 9-28-15. Interview, on 9-30-15 at 3:30 pm, with administrative nursing staff C, revealed the resident stayed up late at night, and then slept in during the morning and was in and out of the facility until dusk. The facility lacked a policy on grooming and activities of daily living needs. The facility failed to provide an opportunity for assistance with bathing and shaving as often as desired by the resident.	F 311		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: The facility reported a census of 38. The 16 residents sampled included 3 reviewed for personal hygiene needs. Based on observation, interview and record review, the facility failed to provide adequate assistance with personal hygiene needs for 2 of the 3 sampled residents	F 312		

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dependent upon staff for for provision of personal hygiene, including #22 with facial shaving and #33 with oral hygiene needs.

Findings included:
- Resident 22 ' s quarterly MDS, dated 8/13/15, documented A BIMS (Brief Interview For Mental Status)and the resident required extensive assistance with dressing, toileting, and personal hygiene needs.

The care plan, reviewed on 8/11/15, revealed the lack of staff guidance for the resident's facial hair removal. The resident would like to be as independent as possible with ADLs but may need staff cueing and or physical assistance, is able to dress self with minimal assist from staff, and staff are to assist with showers 2 times weekly.

Review of the resident ' s ADL echart (electronic medical record), revealed documentation the resident received a bath on 9/28/15, and also that the resident received total assistance with shaving on the night of 9/26/15.

Review of the residents shower list, revealed the resident scheduled to receive showers on Mondays and Saturdays in the mornings.

On 9/29/2015 a 7:18 AM, the resident, fully dressed for the day, sat in the recliner in his/her bedroom. Closer observation revealed facial hair on the resident ' s chin.

The resident was further observed with the facial hair which remained unshaven on the chin, on 9/29/2015 at 4:21 PM and on 9/30/2015 at 10:42 AM.

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F 312	Continued From page 21 On 9/29/2015 at 1:54 PM, direct care staff L, explained the resident ' s facial hair was supposed to be shaved every other day, and at the least, with showers. The staff were supposed to shave him/her, as the resident was unable to do this him/herself. Staff L added, the resident 's facial hair grows very quickly and the staff try to keep it shaved off. The facility failed to ensure this dependent resident received adequate assistance for personal hygiene with facial shaving. - Review of resident #33's signed physician order sheet dated 12/9/14 revealed the following diagnoses: osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), hypocalcemia (low calcium in the blood), dementia (progressive mental disorder characterized by failing memory and confusion), and chronic pain. Review of resident #33's comprehensive MDS (minimum data set) assessment dated 12/22/14	F 312		

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revealed he/she had short and long-term memory problems, and severely impaired cognitive skills for daily decision making. Further review revealed he/she required extensive assist of one staff for personal hygiene. The MDS revealed he/she had no dental issues.

Review of the quarterly MDS dated 9/14/15 revealed resident #33 had short and long term memory problems and severely impaired cognitive skills for daily decision making. Further review revealed he/she required extensive assistance of one staff for personal hygiene. The MDS further revealed he/she had no dental issues noted.

Review of the CAA (care area assessment) for dementia dated 12/22/14 revealed resident #33 was dependent on staff with limited to extensive assistance for all his/her ADL (activities of daily living) cares. The CAA further revealed resident #33 had a history of dementia with short and long-term memory loss with confusion, mood disorders, anxiety, and agitation.

Review of the 12/16/14 care plan revealed he/she had physical and or mental limitations that could affect his/her ability to perform ADLs. The care plan further revealed staff were to assist him/her to maintain good grooming and personal oral hygiene. Further review revealed the resident had his/her own teeth. Staff were to help him/her to clean his/her teeth/mouth twice a day and as needed.

Review of the oral care documentation from 7/1/15-9/30/15 revealed the resident received oral care daily, not twice daily as care planned.

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Observation on 9/29/15 at 11:08 AM revealed direct care staff T and direct care staff U provided oral care with an oral swab. He/she did not resist cares.

Interview with direct care staff T on 9/29/15 at 11:13 AM revealed staff provide oral care twice a day, once upon waking and once before bed. Staff T further stated he/she used an oral swab on the resident.

Interview with direct care staff P on 9/30/15 at 3:44 PM revealed staff provided oral cares and staff were aware he/she had partials to be cleaned. Staff P stated the resident was very good at brushing his/her teeth.

Interview with direct care staff U on 9/30/15 at 11:53 AM revealed staff used an oral swab for his/her oral cares and staff never used a toothbrush.

Interview with licensed staff S on 9/30/15 at 11:58 AM revealed the facility had no formal system in place for oral assessments.

Interview with licensed staff R on 9/30/15 at 4:43 PM revealed the direct care staff performed oral cares for the resident. Staff R further stated direct care staff would use toothbrush and toothpaste for all residents, even with dentures.

Interview with administrative staff C on 9/30/15 at 5:23 PM revealed the staff should have used a toothbrush, but it depended on resident preference.

Review of the Dental Care policy dated 6/2009 revealed on admission the facility staff would

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F 312	Continued From page 24 assess the resident for previous dental work and the need for further dental needs. Each resident should receive daily oral care to ensure the highest level of oral health and oral function. The facility failed to maintain good oral hygiene and provide oral care for resident #33.	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: The facility reported a census of 38 residents. The sample included 16 residents. Through observation, interview, and record review the facility failed to ensure staff provided appropriate assessment and interventions to ensure 1 of 2 residents reviewed for urinary incontinence maintained as much normal bladder function as possible for resident #2. Findings included: - Review of resident #2's signed admission orders dated 5/28/15 revealed the following diagnoses: dementia (progressive mental	F 315		

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disorder characterized by failing memory and confusion), coronary artery disease (CAD-abnormal condition that may affect the flow of oxygen to the heart), chronic pain, and chronic urinary tract infection (UTI).

Review of resident #2's comprehensive MDS (minimum data set) assessment dated 6/5/15 revealed he/she had a BIMS (brief interview for mental status) of zero, indicating severe cognitive impairment. The resident did not have any communication difficulties. He/she exhibited no behaviors or delirium and required supervision of one staff for transfers and walking in and out of his/her room. Further review revealed he/she required extensive assistance of one staff for toilet use. He/she had occasional bladder incontinence and staff used a bladder training program.

Review of the Dementia CAA (care area assessment) dated 6/5/15 revealed resident #2 had short and long-term memory loss with confusion and depended upon staff for ADL (activities of daily living) cares.

Review of resident #2 ' s Urinary Incontinence CAA dated 6/5/15 revealed at times he/she could alert staff he/she needed to use the bathroom. Further review revealed he/she did not alert anyone after he/she had incontinence. He/she did not remember to change his/her adult incontinent product if he/she had incontinence and did not provide hygiene for him/herself, or even remember where the bathroom was. Further review revealed care plan interventions were in effect to decrease his/her incontinence.

Review of the 6/2/15 care plan for resident #2

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revealed staff were to ensure he/she did not have to go to the bathroom before assisted to activities. Further review revealed resident #2 wanted to be continent of bladder and bowel but could not toilet him/herself, therefore staff were to offer to toilet the resident. The care plan revealed resident #2 used incontinent products to keep him/her as dry as possible and odor free. Staff were to assist him/her with toileting needs, provide hygiene needs after each incontinent episode, to help him/her clean him/herself each shift and when he/she had a bowel/bladder accident, and to assist with changing his/her pads. Further review revealed staff were to monitor and document all bowel movements, to assist resident #2 to the toilet every 2 hours during the day, before and after meals, 3-4 times at night, and provide 1-2 staff assist with hygiene and toileting.

Review of resident #2's quarterly MDS dated 9/15/15 revealed no change in the resident ' s cognition, ability to communicate, behaviors, or ADL (activities of daily living) and he/she always had bladder incontinence.

The 6/10/15 care plan revealed staff were to provide good hygiene after each incontinent episode and monitor skin daily. Staff updated the care plan on 8/18/15 revealed the resident had a UTI and a goal the UTI would resolve in 20 days or less with antibiotics given as ordered.

Review of bladder and bowel movement documentation from 6/1/15- 9/30/15 revealed the resident had an average of 3 bladder incontinent episodes and 2 continent episodes per day.

Review of the resident ' s medical record from 6/1/15- 9/30/15 revealed no documentation of a

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bladder training program or a voiding diary.

Review of nurses notes from 6/1/15- 9/30/15 revealed no documentation regarding bladder training or voiding diary.

Observation on 9/29/15 from 7:20 AM until 9:37 AM revealed resident remained seated in his/her wheelchair in the dining room. At 9:37 AM two direct care staff propelled him/her to the restroom in the activity room and provided gait belt assist to transfer the resident to the toilet. Staff prompted him/her to urinate and he/she did so without any obvious problems. Staff provided appropriate hygiene care and resident #2's buttocks looked normal without any areas of redness. The brief, staff removed from the resident remained dry.

Observation on 9/29/15 at 4:02 PM revealed 2 direct care staff assisted resident #2 to the restroom in his/her wheelchair and provided a gait belt assisted transfer to the toilet where the resident urinated upon prompting by staff. Further observation revealed staff removed a dry adult incontinent brief from the resident.

During an interview on 9/30/15 at 11:34 AM direct care staff B reported resident #2 had a general decline since admission. Staff B further reported the facility did not have a system in place to assess the cause for the incontinence, monitor for the incontinence pattern, and/or develop individualized toileting plans for incontinent residents of the special care unit (SCU) to maintain as much normal bladder function as possible. Staff B further reported the facility previously had a process in place, but approximately 18 months ago, the facility stopped using it. Staff B reported voiding assessments

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should be completed every year for residents.

During an interview on 9/30/15 at 3:39 PM, direct care staff P reported resident #2 had been difficult to understand and that he/she needed to be toileted every 2 hours. Staff P further reported the resident had a dry brief most of the time with one wet brief per his/her shift. Staff P further stated resident #2 voided when prompted.

During an interview on 9/30/15 at 4:05 PM, direct care staff H reported resident #2's incontinence had worsened since his/her shingles diagnosis (9/3/15) and he/she declined. Staff H reported resident #2 did not talk much, but urinated if prompted. Staff H reported the resident had more incontinent episodes when he/she had pain. Staff H further reported the resident had a lot of pain after his/her tooth extraction and stopped talking after that time. Staff H stated he/she reported all declines in ADLs to the nurse.

During an interview on 9/30/15 at 4:29 PM licensed nursing staff R reported resident #2 had incontinence but used the toilet more before shingles. Staff R further reported resident #2 had mouth pain and required a soft diet. Staff R reported staff assisted him/her to the restroom every 2-3 hours, before supper, and before bed.

During an interview on 9/30/15 at 5:02 PM Administrative staff C reported resident #2's status had changed a lot since arriving at the SCU. Staff C reported the resident had weight loss, UTIs, and teeth extracted and verified a significant change did occur. Staff C verified the staff did not establish a toileting program.

Per the facility report on 9/30/15, the facility did

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F 315	Continued From page 29 not have a policy for voiding assessments. Review of the facility policy on Management of Urinary Incontinence dated 6/2008 revealed residents who were incontinent of bladder would receive appropriate treatment and devices to prevent urinary tract infections and to restore as much normal bladder function as possible. Further review revealed the policy stated residents would be evaluated upon admission and a 72 consecutive hour voiding diary would be completed. A call to resident #2's physician on 10/1/15 at 9:32 AM was unsuccessful. Staff at the physician's office stated the physician would be out of the office for the week. The facility failed to provide an individualized toileting program to maintain as much bladder continence as possible for resident #2.	F 315		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility reported a census of 38 residents. Based on observation and interview, the facility failed to ensure the residents ' environment	F 323		

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remained as free of accident hazards as possible by the failure to ensure the exit doors had a functioning system to prevent cognitively impaired, independently mobile residents from wandering outside of the facility. Per facility report 13 residents were cognitively impaired and independently mobile.

Findings included:

- Observations on initial tour of the facility on the morning of 9/28/15 revealed the 100 and 200 hall exit doors were unlocked without an activated alarm system.

On 9/29/15 at 7:17 a.m., the door alarm to the 100 hall door located at the end of the special care unit hallway door alarmed appropriately when opened.

An observation on 9/29/15 at 8:45 a.m. revealed the 100 hall exit door opened without sounding an alarm.

During an interview on 9/29/15 at 8:45 a.m. with licensed nursing staff S, he/she stated the nurses reset the alarm when it went off. Staff S reset the 100 hall alarm but it did not lock the door. Staff reset the alarm again and the electronic display read " 15 " (meaning after 15 seconds of pushing on the door with the alarm sounding the door would open) and the door locked.

On 9/29/15 at 10:04 a.m. licensed nursing staff S reset the 100 hall alarm and stated it did not make a noise. Staff S used a key and reset the alarm. The door then would not open, and an alarm voice stated the door could be opened in 12 seconds. Staff S reset the alarm again. Staff S

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stated a resident wearing a WanderGuard (elopement prevention bracelet) must have been near the door. It was pointed out to staff S the electronic display located above the door just had two red dashes showing and the door opened. Staff S stated this should not happen, but should have a " 15 " showing on the electronic display above the door and staff should not be able to just push open the door without waiting the 15 seconds.

During an interview on 9/29/15 at 12:31 p.m., maintenance staff Y stated the facility never had any problems with the 100 hall exit door and did not know what would cause the alarm to turn off.

During an interview on 9/30/15 at 9:30 am, maintenance staff Y explained how the exit doors on each hall functioned, and that the red electronic display located above the door must indicate " 15 " . The 200 hall door opened to an open area (not enclosed) while the 100 hall door opened to a fenced-in area. Staff Y stated the alarms were checked weekly by maintenance. Staff Y also stated staff should check the doors to be sure the " 15 " displayed. Staff Y recommended the doors be checked every shift. Staff Y stated the surge in electricity would not affect them and if the doors were opened they would need to be reset. Staff Y did not know if the facility had a policy for door monitoring. Staff Y confirmed the exit doors in question were not equipped with a WanderGuard system.

During an interview on 9/30/15 at 4:09 p.m. direct care staff H stated it had been a while since a resident tried to get out the door and it was usually the new residents who tried to open the door.

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F 323	Continued From page 32 During an interview on 9/30/15 at 4:30 p.m. administrative nursing staff C stated there was no policy for checking the door alarm system but WanderGuard bracelets were checked weekly for function. At 5:18 p.m., staff C stated if there was a fire drill staff would have to manually lock the doors and reset the alarms. Staff C stated a power surge occurred on the weekend and that staff needed to be trained on how to handle such incidents. The facility does not have a policy on testing the exit doors to make sure they are working properly. The facility failed to ensure the exit doors had a functioning system to prevent cognitively deficient, independently mobile residents from wandering outside of the facility unsupervised into potentially hazardous places.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced	F 325		

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by:
The facility reported a census of 38 residents, with 16 selected for review. Based on observation, interview and record review, the facility failed to provide nutritional services for 2 (#36 and #37), of 3 residents reviewed for weight loss, to prevent weight loss.

Findings included:

- Resident #37 ' s physician order sheet, dated 9-8-15, included diagnoses of dementia (-progressive mental disorder characterized by failing memory, confusion) with unspecified psychosis (any major mental disorder characterized by a gross impairment in reality testing), peptic ulcer disease, esophageal reflux (backflow of stomach contents to the esophagus), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

Review of the resident's medical record, revealed the resident transferred to acute care on 8-21-15, and returned to the facility on 9-8-15.

The admission MDS (minimum data set), dated 8-21-15, assessed the resident with severe cognitive impairment, with fluctuating times of inattention and disorganized thinking. The resident required limited assistance to eat and was without swallowing or dental problems. The record documented a height of 60 inches and current weight of 139 pounds without or unknown weight loss. The resident had received 7 days of

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antidepressant medication and 1 day of antianxiety medication use.

The CAA (care area assessment), dated 8-21-15, for nutrition, advised staff the resident was on a regular diet and could feed him/herself.

The care plan, dated 9-10-15, instructed staff the resident needed assistance at mealtimes and could at times feed him/herself.

The electronic medical record revealed the facility documented the following weights:

On 9-16-15, a weight of 126.8 pounds.
On 9-21-15, a weight of 125.4 pounds.
On 9-28-15, a weight of 129.6 pounds.
On 9-30-15, direct care staff V weighed the resident and reported the weight of 125.6 pounds.

Observation, on 9-29-15 at 7:42 am, revealed the resident with closed eyes in a wheelchair, in the dining room. A cup with pink lemonade sat on the table in front of the resident.

At 8:33 am, (51 minutes later) staff served the resident a plate with a plate guard, which contained biscuits with gravy and scrambled eggs and a bowl of dry fruit loops on the side. The resident continued to sit quietly with his/her eyes closed.

At 8:42 am, (9 minutes later) direct care staff B, sat down beside the resident and assisted the resident to eat. The resident drank 540 cc (cubic centimeters) of fluid with episodes of coughing after swallowing, and a few bites of fruit loops. The resident made attempts to hold a glass of water, but was unable to bring the glass to his/her

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mouth, at which time staff B obtained a straw for the resident.

Interview, on 9-29-15 at 9:59 am, with direct care staff B, revealed the resident was to have a speech evaluation for coughing during his/her meals, but was not aware of any weight loss, and the resident did not receive a nutritional supplement.

Observation, on 9-29-15 at 12:29 pm, revealed the resident seated at the dining table with a plate (without a plate guard) which contained beef stroganoff with noodles, green beans and a slice of bread. At this time, direct care staff T and U took the resident away from the table to use the bathroom. The resident's plate of food remained on the table without cover.

At 12:54 pm, (25 minutes later) staff T returned the resident to the dining room table. The same, uncovered plate of food remained on the table in front of the resident, and staff U began to assist the resident to eat. After further questioning related to the resident ' s uncovered cold food, staff T called the kitchen for another warm plate of food for the resident.

At 1:00 pm, another plate of food arrived from the kitchen, and staff T began feeding the resident the beef stroganoff, which the resident then ate approximately 25%.

Observation, on 9-29-15 at 1:17 pm, revealed the resident coughed on the liquids.

Interview, on 9-29-15 at 1:18 pm, with licensed staff S, revealed the speech therapist could not complete an assessment on the resident due to

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the resident being uncooperative, but had recommended pureed food and nectar thickened liquids. Staff S stated the recommendations were faxed to the physician earlier, but staff could not thicken the resident's liquids or provide a pureed diet until the physician responded to the recommendations.

On 9-29-15 at 6:30 pm, the staff served the resident pureed foods in cups and nectar thickened liquids, but the resident did not consume them.

The facility policy for weights, revised 8-2015, advised staff to obtain weekly weights. The policy advised the certified dietary manager and the director of nursing to consult on weight losses and discuss interventions to prevent further weight loss.

The facility failed to provide consistent dining assistance and dietary assessment for this resident at risk for weight loss.

- Review of resident # 36's electronic admission record, revealed the resident admitted to the facility on 6-12-15.

The history and physical, dated 8-29-15, revealed diagnoses included diabetes, hypothyroidism (condition characterized by decreased activity of the thyroid gland), malnutrition (inadequate nutritional status), with a 10 pound weight loss in the past 6 weeks.

The admission MDS (minimum data set), dated

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6-22-15, assessed the resident with severe cognitive impairment, required supervision for eating, no impairment of extremities, no swallowing or dental problems, a height of 65 inches, and a weight of 149 pounds, with no/unknown weight loss.

The CAA (care area assessment) for dehydration and fluid maintenance, dated 6-24-15, assessed the resident with a diagnoses of dementia, drinks fluids well at meals and snacks, had a history of urinary tract infections.

The CAA for nutrition did not trigger.

The care plan, dated 6-24-15, advised staff of the resident's risk for weight loss due to dementia and the need to weigh the resident weekly, provide ensure with meals and to remind the resident when it is mealtime.

A fax note to the physician, dated 8-5-15, advised the physician of the resident's 10 pound weight loss in 6 weeks and the request for a supplement of the resident's choice to be given with meals.

Review of the weights for the resident, revealed the following:

On 6-23-15, weight of 151 pounds.
On 7-1-15, weight of 151 pounds.
On 8-17-15, weight of 140 pounds.
On 9-28-15, weight of 143 pounds.
On 9-30-15, weight of 145 pounds.

Observation, on 9-29-15 at 7:30 am, revealed the resident seated at the dining room table, drinking ensure.

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Interview, on 9-29-15 at 7:30 am, with direct care staff B, revealed the resident most generally drank the ensure supplement provided at each meal.

Observation, on 9-29-15 at 8:33 am, revealed the resident was served biscuits with gravy and scrambled eggs. The resident consumed 70 % of each.

Observation, on 9-29-15 at 12:29 pm, revealed the resident was seated at the dining table. The resident was served the a plate with a baked potato with chili and cheese, broccoli with cheese, and 8 ounces of ensure. The resident's silverware was wrapped in a napkin beside the plate of food. The resident ate olives and watermelon from 2 small bowls beside the plate of food, with his/her hands, while the silverware remained wrapped in the napkin. A direct care staff member sat across this table assisting another resident but none of the staff noted the problem and assisted the resident to unwrap his/her silverware or asked the resident if he/she would like something else to eat.

At 1:15 pm, the resident's plate of food remained on the table untouched, the ensure had been consumed, and the silverware remained wrapped in the napkin. No staff assisted the resident to unwrap his/her silverware or ask the resident if he/she would like something else to eat.

Interview, on 9-29-15 at 1:30 pm, with direct care staff U, revealed direct care staff assisted the residents to eat, but did get called away to toilet residents or answer call lights, so meals were frequently interrupted.

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F 325	Continued From page 39 The facility policy for weights, revised 8-2015, advised staff to obtain weekly weights. The facility failed to provide consistent dining assistance and weekly weights for this resident at risk for weight loss.	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: F329-D	F 329		

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The facility reported a census of 38 residents with 16 residents included in the sample. Based on observation, interview, and record review, the facility failed to ensure 2 of 5 residents reviewed for unnecessary medications received adequate monitoring for antihypertensive medications, monitoring for PRN (as needed) medications (#25 and #31), and adequate justification of use (#31).

Findings included:

- Review of resident #25's physician signed history and physical revealed diagnoses including frontotemporal lobe dementia (a progressive mental disorder characterized by failing memory and confusion), depressive disorder (an abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, and emptiness), hypertension (elevated blood pressure) and psychosis (any major mental disorder characterized by a gross impairment in reality testing) with behaviors.

Review of the resident's Comprehensive MDS (Minimum Data Set) dated 10/14/14 revealed a BIMS (Brief Interview for Mental Status) score of 0, indicating severe cognitive impairment. During the 7-day observation period, he/she received an antidepressant and antibiotic daily.

Review of the Psychosocial Well-Being CAA (Care Area Assessment) dated 10/20/14 revealed the resident had a diagnosis of dementia and depression. The resident had short and long term memory loss with confusion.

Review of the resident's Quarterly MDS dated 6/25/15 revealed the resident had both short and

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long-term memory problems and the resident had severely impaired cognitive skills for daily decision making. During the 7-day observation period, he/she received an antidepressant daily.

Review of the resident's care plan, initiated 10/30/13, revealed medications were to be administered as prescribed. Staff were to monitor the resident for hypotension (low blood pressure) and constipation.

Review of the physician's orders revealed the following medications with their start dates:

1/22/14- Lorazepam Plogel (an antianxiety medication) 1 mg (milligram) topically PRN (as needed) every four hours.
7/17/14- Metoprolol Succinate (an antihypertensive medication) 25 mg by mouth daily (Hold if apical pulse <60 BPM).
6/20/15 Milk of Magnesia (MOM) 400 mg/5 mL (milliliter) administer 30 mL by mouth PRN every 3 days.

Review of the July 2015 MAR (Medical Administration Record) revealed staff administered Lorazepam Plogel 1mg on 7/21/15 but did not document the reason or follow up for effectiveness.

Review of the August 2015 MAR revealed staff administered MOM on 8/31/15 according to the BM (bowel movement) list but staff did not follow-up for effectiveness.

Review of the September 2015 MAR revealed staff administered MOM on 9/3/15. Staff documented the reason given as " list " and did not follow-up for effectiveness.

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Record review revealed staff did not obtain the resident's pulse rate before administering Metoprolol 25 of 31 days in July 2015, 27 of 30 days in August 2015, and 23 of 30 days in September 2015.

An observation on 9/30/15 at 3:00 PM revealed the resident sat in the special care unit activity room with other residents watching TV. The resident was calm and did not exhibit any negative behaviors and responded appropriately when talked to.

During an interview on 9/30/15 at 3:17PM, direct care staff Q stated he/she checked pulses and blood pressures in the morning before giving medications which required it. Staff Q stated resident #25 was not one of the residents he/she checked pulses for. Staff Q verified the order for Metoprolol clearly stated the medication should be held for a pulse rate less than 60 BPM (beats per minute).

During an interview on 9/30/15 at 3:32 PM, licensed nursing staff K verified the physician's order for Metoprolol stated to hold medication if the resident had a heart rate of less than 60 BPM.

During an interview on 9/30/15 at 4:08 PM, administrative nursing staff C stated he/she expected a nurse or certified medication aide to obtain a pulse prior to administering a medication if the doctor ordered it. Staff C also expected there to be a reason staff administered a PRN medication and follow-up for effectiveness.

Review of the facility's Medication Administration policy last updated 3/2009, revealed following the

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administration of a PRN medication, a follow up assessment by licensed nursing staff should be done to determine effectiveness of the PRN medication.

The facility failed to ensure follow up for effectiveness for PRN medications given and monitoring of the resident's pulse as ordered before administering medication as ordered for resident #25.

- The electronic chart revealed resident # 31, admitted on 8/26/14, with the following diagnoses including; depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), psychosis (any major mental disorder characterized by a gross impairment in reality testing), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

The Quarterly MDS (minimum data set), dated 6/5/15, revealed the resident had a BIMS (brief interview for mental status) score of 15, indicating intact cognition. The resident had no signs or symptoms of delirium. Mood score of 3, which

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revealed minimal depression. The mood interview revealed the resident had feelings of being down, depressed, or hopeless, and had trouble falling or staying asleep, or sleeping too much on 1 day or less. The resident received antipsychotic, anti-depressant and hypnotic medications.

The Annual MDS, dated 9/2/15, revealed the resident ' s mood interview scored a 1, which revealed minimal depression. The resident had diagnosis which included depression. The resident had 1 non -major injury fall since admission or prior assessment. The resident was on antipsychotic, antidepressant, hypnotic, anticoagulant, and diuretic.

The CAA (care area assessment), dated 9/10/15, revealed in the psychotropic drug use area, the resident was on antipsychotic, antidepressant and hypnotic medication, and documented when a reduction in some of his/her medications were tried, the resident became easily angered and irritated. The resident received the hypnotic as a sleep aide, and received the medication of Lexapro for depression, Xanax for anxiety and Risperdal for psychosis. The resident was alert and oriented, and could make his/her own decisions. The CAA lacked documentation for the psychosocial or mood state or behavioral symptoms for the resident.

The care plan, reviewed on 6/2/15, instructed staff if the resident was unable to fall asleep, watch television to help relax, or provide food or drink and keep the head of the bed elevated.

Review of the physician ' s orders included:

On 3/21/15 - Temazepam (Restoril) (A hypnotic

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medication) 30 mg (mlligrams), daily, for Depressive disorder.

On 8/31/15- Risperidone (Risperdal) (antipsychotic medication), 0.25 mg, po (by mouth), 2 times daily, for psychosis.

Review of the EMAR (electronic medication administration record) monthly report, documented on 8/31/15 at 1800 (6:00 PM), the resident received Risperidone 0.25 mg, by licensed nursing staff W, and also the resident received Risperidone ODT 0.25 mg at 1800 by direct care staff Q.

On 9/30/2015 at 3:10 PM, direct care staff Q, stated the Risperidone ODT should have been pulled out of the medication cart prior to the medication error incident.

On 9/30/15 at 3:29 PM, administrative nursing staff C, reviewed the monthly EMAR documentation, and verified the documentation revealed the resident was given an additional dose of Risperidone on 8/31/15 at 6:00 PM.

Furthermore, review of the assessments on the electronic record lacked a hypnotic or sleep assessment for this resident who received a daily hypnotic medication.

The resident ' s Focused on high risk medications for the elderly form, dated 6/8/15, included the resident ' s medications for physician review: Risperdal, 0.25 mg, BID (twice a day) and Temazepam, 30 mg, at bedtime. The form documented the medications presented a potential risks for the resident. The form indicated

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if the patient should continue to receive the medications, the physician should mark the box with, No, Continue, and then indicate the reasons why so the records could be updated. The physician documented to continue for the resident ' s diagnoses. However, the form lacked the physician ' s factors related to a risk versus benefits statement to explain the reasoning for the continued use of these medications for the resident.

On 9/30/2015 at 8:18 AM, Licensed nursing staff K, stated the Restoril (Hypnotic) was to be given for insomnia.

On 9/30/2015 at 2:51 PM, Licensed nursing staff K, stated the resident had a problem with sleep, and that the resident did not have a regular sleep pattern. Licensed nursing staff K verified the facility failed to complete a sleep assessment for the resident.

On 9/30/2015 at 3:29:42 PM, administrative nursing staff C, stated the Restoril was not generally given for depressive disorder, and stated the resident did have difficulty with sleeping. Administrative nursing staff C stated no sleep assessment or sleep program was completed for this resident.

Review of a Medication Administration policy dated 3/2009 revealed medication administration would be done in a safe and orderly manner.

The facility failed to ensure the resident ' s Risperidone medication remained free of excessive medication dosage. Furthermore, the facility failed to assess the resident ' s sleep for the extended use of the hypnotic medication

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F 329	Continued From page 47 without risk versus benefit reasons from the physician.	F 329		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: The facility census totaled 38 residents, with 16 included in the sample. Based on observation, interview, and record review, the facility failed to ensure 1 of 5 residents reviewed for unnecessary medications were free of significant medication errors. (#28) Findings included: - Review of resident #28 ' s physician progress note dated 4/11/14, revealed diagnoses of unspecified psychosis (any major mental disorder characterized by a gross impairment in reality testing) and insomnia (inability to fall asleep and stay asleep). Review of an electronically signed physician order sheet dated 8/28/15 revealed additional diagnoses of depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), hypothyroidism (when the body does not produce enough thyroid hormone), depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), dementia (progressive mental disorder characterized by failing memory, confusion) with behavioral disturbance, and	F 333		

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anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

The quarterly MDS (minimum data set) dated 1/13/15, revealed he/she had a BIMS (brief interview for mental stats) of 0, indicating severe cognitive impairment. He/she exhibited no signs of delirium or behaviors. The resident was independent with bed mobility, transfers, and walking in the room and corridor. The resident received daily antidepressant medication and 3 days of antibiotics during the 7-day observation period.

The annual MDS dated 7/16/15, revealed he/she had no change in cognition, behaviors, or ADL (activities of daily living) ability from the previous assessment. The resident received antipsychotic and antidepressant medications daily during the 7-day observation period.

Review of the Psychotropic Drug Use CAA (care area assessment) dated 7/16/15, revealed the resident received Geodon (an antipsychotic medication) for psychosis. Resident #28 had adjusted to placement in the SCU (special care unit). His/her behaviors had improved and he/she was more compliant with cares such as shaving and showering. The resident ' s medications would be routinely reviewed by the director of nursing, consulting pharmacist, and physician. The resident had a history of dementia with behaviors, depression, anxiety and psychosis. The resident received Lexapro and Trazodone for depression.

Review of the resident ' s care plan initiated 4/18/14, revealed the resident had resistive

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behaviors (resisting care and or treatment) and had a goal for stabilization or decline in the frequency of resistive behaviors within the next 90 days. Interventions directed staff to administer medications as prescribed, including antidepressant medications Lexapro and trazadone. Monitor and report any drug related symptoms to the physician or physician extenders.

Review of the 7/23/15 Medication management care plan, revealed the following medications:
· Exelon for dementia/memory enhancement. Monitor for cognitive and memory status. Do not place patch in same spot for 14 days and the exact spot should be rotated.
· Levothyroxine for hypothyroidism.
· Namenda XR for memory enhancement.
· Trazadone for depression. Monitor for worsening depression.

Review of an electronically signed medication list, included in a physician ' s visit note dated 8/28/15, revealed the following medications with their start dates:

2/21/15- Exelon patch 9.5 mg/24 hours 1 patch topical daily for dementia with behavioral disturbance.
12/30/14- Levothyroxine sodium 75 mcg by mouth (PO) one time daily for unspecified hypothyroidism.
12/30/14- Lexapro 40 mg PO daily for depressive disorder.
4/6/15- Trazodone 50 mg PO at bedtime for depression.
2/21/15- Namenda XR 28 mg PO daily for dementia with behavioral disturbances.

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Review of a physician note dated 5/8/15, revealed the physician saw the resident for a yearly history and physical. The resident had a seizure related to the use of Exelon patches. Staff noted they were not removing the old patch when placing a new patch. The physician had discontinued the Exelon patch; however, the resident began to develop worsening inappropriate behaviors towards staff. The physician restarted the Exelon patch at a lower dose and the resident ' s behaviors had since improved significantly.

Review of a Nursing/Physician report dated 6/6/15, revealed a direct care staff found 2 Exelon patches on the resident ' s back that were both dated 6/6/15. Staff removed both patches at bedtime that night.

Review of a Nursing /Physician report dated 8/5/15, revealed the facility did not have the resident ' s Lexapro, Namenda, levothyroxine and trazodone from 8/1/15-8/4/15, so the resident had not received it. The resident experienced increased shaking in his/her extremities, diarrhea, emesis (vomiting), and headache. Staff picked up the medication on the afternoon of 8/4/15 and administered it to him/her. The resident ' s headache, diarrhea, and emesis subsided. The physician replied for staff to make sure the medications were not discontinued again.

Review of the pharmacist ' s drug regimen reviews dated:
6/11/15, revealed the pharmacist identified an incident report regarding staff finding the resident with two Exelon patches on, noted by a direct care staff.
7/11/15, revealed a recent dose reduction for Geodon, but it did not indicate the pharmacist

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identified the omission of the drug for 12 days. 8/10/15, revealed no concerns. The pharmacist did not identify the facility ' s failure to administer the resident ' s Lexapro, Namenda, levothyroxine, and trazadone.

Observation on 9/30/15 at 8:09 AM, revealed direct care staff Q gave the resident medications and he/she took them without any issues.

An attempt on 9/29/15 at 3:07 PM, revealed the resident did not want to be interviewed.

On 9/30/15 at 11:45 AM, direct care staff Q explained the facility system for medications reordering; He/she stated when a resident ' s medication card had only about 5 days left, the CMA (certified medication aide) faxed the pharmacy alerting them the resident needed a refill. Then if the CMA noticed the medication had not come in from the pharmacy and the resident got really low on the medication, the CMA reported to the charge nurse, who then called the pharmacy. Staff Q stated the problem of running out of medications for residents was due to out-of-town pharmacies. Staff Q stated it had happened that residents went without medications when the re-orders did not come in on time. Staff Q reported he/she knew of several days when the resident went without medications because they were not available.

Interview with licensed nursing staff R, on 9/30/15 at 4:45 PM, revealed at one point, the resident did not receive medications for days. Staff R reported the resident ' s medications came from a pharmacy located in another town and that pharmacy only delivered on Mondays, Wednesdays, or Fridays. Staff R reported at

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F 333	Continued From page 52 times, a maintenance staff member picked up medications if the resident really needed them. Staff R reported usually the CMA re-ordered medications and any medication that came from another town ' s pharmacy, staff ordered 7 days before the resident actually ran out of the medication. Staff R reported if the facility did not receive the medications in time, staff looked in the emergency medication kit first, then called the pharmacy in town, or borrowed the medication from the hospital. Staff R confirmed no one had done that for resident #28 and he/she did not get his/her medications as ordered on a few occasions. Interview on 9/30/15 at 5:15 PM, with administrative nurse C revealed the resident should not have gone without his/her medications and the facility needed to work on their process to ensure residents received their medications as ordered. Nurse C reported he/she knew of the incidents regarding the medications that were not administered as well as the incident with the dual Exelon patches. Review of the facility policy for Medication Administration, reviewed on 8/2009, revealed when administering medications, staff were to follow the six rights of medication administration (time, person, dose, medication, route, and documentation). The facility failed to ensure staff safely and accurately administered the resident ' s medications, resulting in two separate medication errors.	F 333		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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The facility must -
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and
(2) Store, prepare, distribute and serve food under sanitary conditions

This REQUIREMENT is not met as evidenced by:
The facility census totaled 38 residents. The facility served food to all residents from one main kitchen into two separate dining rooms. Based on observation, interview, and record review, the facility failed to ensure staff served foods in a sanitary manner and to ensure staff properly labeled containers with open dates and contents.

Findings included:

- During an observation on 9/30/15 at 4:20 PM, the refrigerator in the special care unit (SCU) contained:
· 3 unlabeled/undated desserts in small glasses with a container of an unidentified orange colored fruit in a plastic container with each dessert
· a plastic bottle labeled as butter with a date of 8/9/15 with no expiration date
· a zip lock bag with sliced summer sausage with no label or date
· a small plate of sliced cheese with no label or date
The freezer contained a 1 pint container of ice cream with no open date or expiration date and a

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gallon size zip lock bag with white powder labeled as flour without an open date on the bag. The freezer did not contain a thermometer for monitoring the freezer temperatures.

On 9/28/15 at 8:50 AM, observation of the SCU dining room revealed a steam table cart entered. Dietary staff A served breakfast plates to the residents. Staff A wore gloves and used utensils to place scrambled eggs on the plate, and tongs for bacon and sausage for the first few plates. However, he/she also picked up the toast and muffins with the same gloves he/she had touched the plate, utensils, pans, and other surfaces. During service of approximately half of the residents of the SCU, staff A also used his/her contaminated gloved hands to pick up bacon and placed it on the plates. During this time, dietary staff O, who assisted in the SCU dining room, staff O pushed around a cart with dry cereals while wearing single-use gloves. Staff O then used the same gloved hands to place over the pour spout of the dry cereal containers, when pouring out the dry cereal. The dry cereal touched directly on staff O ' s contaminated gloved hand before going on into the residents individual bowls.

On 9/28/15 at 10:45 AM, in the SCU living room, direct care staff B put on a pair of single-use gloves, picked up a plate of cookies, touched the 3 tier cart, and then used the same contaminated gloved hand to pick up each cookie and handed them to 6 different residents.

On 9/30/15 at 8:45, administrative nurse N, stated this was not acceptable.

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F 371	Continued From page 55 The facility failed to ensure staff served foods in a sanitary manner by the failure to appropriately use single-use gloves and failed to ensure staff labeled foods with open dates and contents.	F 371		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: The facility census totaled 38 residents, with 16 included in the sample. Based on observation, interview, and record review, the facility failed to maintain an effective procedure to ensure the provision of medications/pharmaceutical services, to meet the needs of 3 of 5 sampled residents reviewed for unnecessary medications. (#28, #31,	F 425		

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F 425	Continued From page 56 and #25) Findings included: - Review of resident #28 ' s physician progress note dated 4/11/14, revealed a diagnosis of unspecified psychosis (any major mental disorder characterized by a gross impairment in reality testing). Review of an electronically signed physician order sheet dated 8/28/15, revealed additional diagnoses of depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), dementia (progressive mental disorder characterized by failing memory, confusion) with behavioral disturbance, and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). Review of the resident ' s quarterly MDS (minimum data set) dated 1/13/15, revealed he/she had a BIMS (brief interview for mental stats) of 0, indicating severe cognitive impairment. He/she exhibited no signs of delirium or behaviors. The resident was independent with bed mobility, transfers, and walking in the room and corridor. The resident received daily antidepressant medication and 3 days of antibiotics during the 7-day observation period. Review of the resident ' s annual MDS dated 7/16/15, revealed he/she had no change in cognition, behaviors, or ADL (activities of daily living) ability from the previous assessment. The resident received antipsychotic and	F 425		

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antidepressant medications daily during the 7-day observation period.

Review of the Psychotropic Drug Use CAA (care area assessment) dated 7/16/15, revealed the resident received Geodon (an antipsychotic medication) for psychosis. The resident had adjusted to placement in the SCU (special care unit). His/her behaviors had improved and he/she was more compliant with cares such as shaving and showering. The resident ' s medications would be routinely reviewed by the director of nursing, consulting pharmacist, and physician. The resident had a history of dementia with behaviors, depression, anxiety and psychosis.

Review of the resident ' s care plan dated 4/18/14, revealed the resident had resistive behaviors (resisting care and or treatment) and had a goal for stabilization or decline in the frequency of resistive behaviors within the next 90 days. Interventions directed staff to administer medications as prescribed.

Review of the electronically signed physician orders dated 8/28/15, revealed an order for Geodon 20 milligrams (mg) twice daily initially ordered on 6/24/15, for unspecified psychosis.

Review of a 6/23/15 nursing/physician report, revealed staff noted the resident did not receive his/her Geodon since 6/9/15, until 6/22/15, a time period of 12 days. Staff did not administer the Geodon due to medication not available in the cart. Staff found the medication in the overstock drawer in medication room on 6/21/15 in the evening. The physician then ordered staff to decrease the Geodon to 20 mg, by mouth, every morning and to monitor the resident for

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behaviors.

Review of the pharmacist ' s drug regimen review, dated 7/11/15, revealed a recent dose reduction for the resident ' s Geodon, but it did not indicate the pharmacist identified the omission of the drug for 12 days.

Observation on 9/30/15 at 8:09 AM, revealed direct care staff Q administered medications to the resident who took them without any issues.

An attempt on 9/29/15 at 3:07 PM, revealed the resident did not want to be interviewed.

On 9/30/15 at 11:45 AM, direct care staff Q explained the facility system for medications reordering; He/she stated when a resident ' s medication card had only about 5 days left, the CMA (certified medication aide) faxed the pharmacy alerting them the resident needed a refill. Then if the CMA noticed the medication had not come in from the pharmacy and the resident got really low on the medication, the CMA reported to the charge nurse, who then called the pharmacy. Staff Q stated the problem of running out of medications for residents was due to out-of-town pharmacies. Staff Q stated it had happened the residents went without medications when the re-orders did not come in on time. Staff Q reported he/she knew of several days when resident #28 went without physician ordered medications because they were not available.

Interview, with licensed nursing R, on 9/30/15 at 4:45 PM, revealed at one point, the resident did not receive medications for days. Staff R reported the resident ' s medications came from a pharmacy located in another town and that

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pharmacy only delivered on Mondays, Wednesdays, or Fridays. Staff R further explained, a maintenance staff member picked up medications if the resident really needed them. Staff R reported usually the CMA re-ordered medications and any medication that came from a pharmacy in another town, staff were to reorder 7 days before the resident actually ran out of the medication. Staff R reported if the facility did not receive the medications in time, staff looked in the emergency medication kit first, then called the pharmacy in town, or borrowed the medication from the hospital. Staff R confirmed no one had done that for resident #28 and he/she did not get his/her medications as ordered on a few occasions.

Interview on 9/30/15 at 5:15 PM, with administrative nurse C revealed resident #28 should not have gone without his/her medications and the facility needed to work on their process to ensure residents received their medications as ordered.

Review of the facility policy for Psychotropic Medication Usage and Monitoring, revised 8/2015, revealed nursing staff would be responsible for following medication monitoring and intervention procedures to ensure the appropriate administration procedure of each psychotropic medication.

The facility failed to ensure resident #28 received Geodon as ordered for 12 days in June 2015.
- Review of resident #25 ' s physician signed history and physical revealed diagnoses including frontotemporal lobe dementia (a progressive mental disorder characterized by failing memory and confusion), depressive disorder (an abnormal

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emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), hypertension (elevated blood pressure), and psychosis (any major mental disorder characterized by a gross impairment in reality testing) with behaviors.

Review of the resident ' s Comprehensive MDS (Minimum Data Set) dated 10/14/14 revealed a BIMS (Brief Interview for Mental Status) score of 0, indicating severe cognitive impairment. During the 7-day observation he/she received an antidepressant and an antibiotic daily.

Review of the Psychosocial Well-Being CAA (Care Area Assessment) dated 10/20/14 revealed the resident had a diagnosis of dementia and depression. The resident had short and long-term memory loss with confusion.

Review of the resident ' s care plan, initiated 10/30/13, revealed medications were to be administered as prescribed.

Review of the physician ' s orders revealed medications with the following start dates:
· 7/21/15- Levaquin (an antibiotic) 500 mg (milligrams) PO (by mouth) administer daily for 5 days for an upper respiratory infection.
· 9/29/15- Olanzepine (Zyprexa) 2.5 mg PO daily for 1 week then 5 mg daily.

Review of the July 2015 MAR (Medical Administration Record) revealed: Levaquin " not present on med (medication) cart " on 7/22/15 and the resident refused on 7/26/15. The physician ordered for the resident to receive 5 days of antibiotics for an upper respiratory infection, but documentation showed the resident

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only received it for 3 days.

Review of the September 2015 MAR revealed: Zyprexa " med not on cart " on 9/29/15 and 9/30/15.

Review of the Progress Note dated 9/29/15 written by licensed nurse S stated the Zyprexa had not arrived from the pharmacy from another town.

Review of the Progress Note dated 9/30/15 written by licensed nurse S stated the staff contacted the pharmacy regarding the delivery of the Zyprexa and the pharmacy stated it should be delivered this afternoon.

An observation on 9/30/15 at 3:00 PM revealed the resident sat in the special care unit activity room with other residents watching TV. The resident acted calmly and did not exhibit any negative behaviors.

During an interview on 9/30/15 at 5:42 PM, licensed nursing staff R stated if an antibiotic was missed due to not being available or the resident refused the medication, he/she would contact the doctor to notify them of the situation to see if staff needed to continue to finish the missed doses. Staff R stated resident #25 should have completed the series as ordered, and confirmed the resident was only given the ordered antibiotic medication 3 out of 5 days ordered.

During an interview on 9/30/15 at 5:52 PM, administrative nursing staff C stated the nurse should have made a separate order to add 2 days to the antibiotic entry for the doses that were missed in order for the resident to complete the

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antibiotic as ordered. Staff C confirmed this was not done according to the July 2015 MAR Monthly Report.

Review of the facility ' s Medication Administration policy last updated 3/2009, revealed staff were to notify the physician shall be notified by the charge nurse if any medications were held.

The facility failed to ensure resident #25 received medications as ordered.

- The resident did not have signed or electronic signed physician orders. The electronic chart revealed resident #31, admitted on 8/26/14, with the following diagnoses including: chronic obstructive asthma (chronic inflammatory disease of the airways characterized by variable and recurring symptoms, reversible airflow obstruction), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), and congestive heart failure (a condition with low heart output and the body becomes congested with fluid).

The annual MDS (minimum data set), dated 9/2/15, revealed the resident had a BIMS (brief interview for mental status) score of 15, indicating intact cognition. The resident received a diuretic medication during the 7 day observation period.

The care plan, reviewed on 6/2/15, guided staff to monitor for edema in the lower extremities. It also notified staff the resident had an increased risk for falls due to weakness and shortness of breath with exertion.

Review of the physician orders included the

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F 425	Continued From page 63 following medications with start dates: · 1/1/15 -Albuterol sulfate nebulizer 4 times a day for chronic obstructive asthma · 12/31/14- Bumetanide 2 mg (milligrams) po (by mouth) 2 times daily for edema · 12/31/14- Ipratripium bromide (Atrovent) inhalation 4 times a day for chronic obstructive asthma Review of the EMAR (electronic medication administration record) monthly reports from July to September 2015: · Staff documented the inhalation medication Ipratripium bromide was not administered 9 times. The medication was omitted on 7/ 4/15, 7/8/15, 7/21/15, 8/5/15, 8/9/15, 9/1/15 and, 9/6/15. · Staff did not administer Albuterol sulfate inhalation solution 8 times. The medication was omitted on 7/8/15, 7/21/15, 7/21/15, 8/5/15, 8/9/15, 9/1/15, 9/6/15, and 9/26/15. · Staff did not administer Bumetanide on 8/14/15 and 9/26/15. On 9/30/15 at 3:29 PM administrative nursing staff C verified there were medication omissions in the electronic records, and stated the previous director of nurses used to audit the charting for omissions, but stated he/she had not started checking to ensure staff administered medications as ordered. Review of a Medication Administration policy dated 3/2009 revealed the physician should be notified anytime medications were held and medication administration would be done in a safe and orderly manner. The facility failed to ensure resident #31 received	F 425		

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F 425	Continued From page 64 the necessary medications for his/her well-being.	F 425		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: The facility reported a census of 38 residents with 16 included in the sample. Five residents were selected for review of unnecessary medications. Based on observation, interview and record review, the facility failed to ensure the pharmacist identified and reported any irregularities of drug regimen reviews for 4 of 5 residents (#25, #28, #8 and #31). Findings included: - Review of resident #25 ' s physician signed history and physical revealed diagnoses including frontotemporal lobe dementia (a progressive mental disorder characterized by failing memory and confusion), depressive disorder (an abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, and emptiness), hypertension (elevated blood pressure) and psychosis (any major mental	F 428		

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disorder characterized by a gross impairment in reality testing) with behaviors.

Review of the resident ' s Comprehensive MDS (Minimum Data Set) dated 10/14/14 revealed a BIMS (Brief Interview for Mental Status) score of 0, indicating severe cognitive impairment. During the 7-day observation period, he/she received an antidepressant and antibiotic daily.

Review of the Psychosocial Well-Being CAA (Care Area Assessment) dated 10/20/14 revealed the resident had a diagnosis of dementia and depression. The resident had short and long term memory loss with confusion.

Review of the resident ' s Quarterly MDS dated 6/25/15 revealed the resident had both short and long-term memory problems and the resident had severely impaired cognitive skills for daily decision making. During the 7-day observation period, he/she received an antidepressant daily.

Review of the resident ' s care plan, initiated 10/30/13, revealed medications were to be administered as prescribed.

Review of the physician ' s orders revealed the following order with start date: 7/21/15- Levaquin (an antibiotic) 500 mg (milligrams) PO (by mouth) administer daily for 5 days for an upper respiratory infection.

Review of the July 2015 MAR (Medical Administration Record) revealed: Levaquin " not present on med (medication) cart " on 7/22/15 and the resident refused on 7/26/15. The physician ordered for the resident to receive 5 days of antibiotics for an upper respiratory

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infection, but documentation showed the resident only received it for 3 days.

Review of resident ' s medical records revealed the consultant pharmacist staff X completed a monthly medication review on 8/10/15 and failed to identify resident #25 did not complete the series of antibiotics as ordered.

An observation on 9/30/15 at 3:00 PM revealed the resident sat in the special care unit activity room with other residents watching TV. The resident acted calmly and did not exhibit any negative behaviors.

During an interview on 9/30/15 at 5:42 PM, licensed nursing staff R confirmed resident #25 only received the ordered antibiotic medication 3 out of 5 days.

During an interview on 9/30/15 at 3:30 PM, administrative nursing staff C stated the nurse should have made a separate order to add the 2 days that the antibiotic was missed in order for the resident to complete the antibiotic as ordered. Staff C confirmed this was not done according to the July 2015 EMAR Monthly Report. Staff C reported the pharmacist reviewed medications regimens monthly of all the residents, then he/she got a copy of the pharmacist ' s recommendations. After he/she looked through the recommendations, he/she reported faxing them to the physician, and then once he/she got them back from the physician, he/she faxed them back to the pharmacist.

An attempt to contact pharmacy consultant staff X for an interview on 10/1/15 at 2:16 pm was unsuccessful as staff X was not available.

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The facility failed to ensure the consultant pharmacist identified irregularities in medication administration when resident #25 did not receive antibiotics as ordered.

- Review of resident #28 ' s physician progress note dated 4/11/14, revealed diagnoses of unspecified psychosis (any major mental disorder characterized by a gross impairment in reality testing) and insomnia (inability to fall asleep and stay asleep). Review of an electronically signed physician order sheet dated 8/28/15 revealed additional diagnoses of depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), hypothyroidism (when the body does not produce enough thyroid hormone), depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), dementia (progressive mental disorder characterized by failing memory, confusion) with behavioral disturbance, and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

The quarterly MDS (minimum data set) dated 1/13/15, revealed he/she had a BIMS (brief interview for mental stats) of 0, indicating severe cognitive impairment. He/she exhibited no signs of delirium or behaviors. The resident received daily antidepressant medication and 3 days of antibiotics during the 7-day observation period.

The annual MDS dated 7/16/15, revealed he/she had no change in cognition or behaviors from the previous assessment. The resident received

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antipsychotic and antidepressant medications daily during the 7-day observation period.

Review of the Psychotropic Drug Use CAA (care area assessment) dated 7/16/15, revealed the resident received Geodon (an antipsychotic medication) for psychosis. The resident's medications would be routinely reviewed by the director of nursing, consulting pharmacist, and physician. The resident had a history of dementia with behaviors, depression, anxiety and psychosis. The resident received Lexapro and Trazodone for depression.

Review of the resident's care plan initiated 4/18/14, revealed the resident had resistive behaviors (resisting care and or treatment) and had a goal for stabilization or decline in the frequency of resistive behaviors within the next 90 days. Interventions directed staff to administer medications as prescribed, including antidepressant medications Lexapro and trazadone. Monitor and report any drug related symptoms to the physician or physician extenders.

Review of the 7/23/15 Medication management care plan, revealed the following medications:
· Exelon for dementia/memory enhancement. Monitor for cognitive and memory status. Do not place patch in same spot for 14 days and the exact spot should be rotated.
· Levothyroxine for hypothyroidism.
· Namenda XR for memory enhancement.
· Trazadone for depression. Monitor for worsening depression.

Review of an electronically signed medication list, included in a physician's visit note dated 8/28/15,

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revealed the following medications with their start dates:
· 2/21/15- Exelon patch 9.5 mg/24 hours 1 patch topical daily for dementia with behavioral disturbance.
· 12/30/14- Levothyroxine sodium 75 mcg by mouth (PO) one time daily for unspecified hypothyroidism.
· 12/30/14- Lexapro 40 mg PO daily for depressive disorder.
· 4/6/15- Trazodone 50 mg PO at bedtime for depression.
· 2/21/15- Namenda XR 28 mg PO daily for dementia with behavioral disturbances.

Review of a physician note dated 5/8/15, revealed the physician saw the resident for a yearly history and physical. The resident had a seizure related to the use of Exelon patches. Staff noted they were not removing the old patch when placing a new patch. The physician had discontinued the Exelon patch; however, the resident began to develop worsening inappropriate behaviors towards staff. The physician restarted the Exelon patch at a lower dose and the resident's behaviors had since improved significantly.

Review of a Nursing/Physician report dated 6/6/15, revealed a direct care staff found 2 Exelon patches on the resident's back that were both dated 6/6/15. Staff removed both patches at bedtime that night.

Review of a Nursing /Physician report dated 8/5/15, revealed the facility did not have the resident's Lexapro, Namenda, levothyroxine and trazodone from 8/1/15-8/4/15, so the resident had not received it. The resident experienced increased shaking in his/her extremities, diarrhea,

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emesis (vomiting), and headache. Staff picked up the medication on the afternoon of 8/4/15 and administered it to him/her. The resident's headache, diarrhea, and emesis subsided. The physician replied for staff to make sure the medications were not discontinued again.

Review of the pharmacist's drug regimen reviews dated:
6/11/15- revealed the pharmacist identified an incident report regarding staff finding the resident with two Exelon patches on, noted by a direct care staff.
7/11/15- revealed a recent dose reduction for Geodon, but it did not indicate the pharmacist identified the omission of the drug for 12 days.
8/10/15- revealed no concerns. The pharmacist did not identify the facility's failure to administer the resident's Lexapro, Namenda, levothyroxine, and trazadone.

Observation on 9/30/15 at 8:09 AM revealed direct care staff Q gave the resident medications and he/she took them without any issues.

An attempt on 9/29/15 at 3:07 PM revealed the resident did not want to be interviewed.

Interview with licensed nursing staff R on 9/30/15 at 4:45 PM, revealed at one point, the resident did not receive medications for days. Staff R reported at times, a maintenance staff member picked up medications if the resident really needed them. Staff R reported if the facility did not receive the medications in time, staff looked in the emergency medication kit first, then called the pharmacy in town, or borrowed the medication from the hospital. Staff R confirmed no one had done that for resident #28 and he/she did not get

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his/her medications as ordered on a few occasions.

Interview on 9/30/15 at 5:15 PM with administrative nurse C revealed the resident should not have gone without his/her medications and the facility needed to work on their process to ensure residents received their medications as ordered. Nurse C reported he/she knew of the incidents regarding the medications that were not administered as well as the incident with the dual Exelon patches.

On 10/1/15 at 10:01 AM, Consultant pharmacist X was unavailable for interview.

Review of the facility policy for Medication Administration, reviewed on 8/2009, revealed when administering medications, staff were to follow the six rights of medication administration (time, person, dose, medication, route, and documentation).

The facility failed to ensure Consultant Pharmacist X identified irregularities in medication administration for resident #28.

- The electronic chart revealed resident #31, admitted on 8/26/14, with the following diagnoses including depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), psychosis (any major mental disorder characterized by a gross impairment in reality testing), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

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The Quarterly MDS (minimum data set) dated 6/5/15 revealed the resident had a BIMS (brief interview for mental status) score of 15, indicating intact cognition. The resident had no signs or symptoms of delirium. The resident had a total mood severity score of 3, which revealed minimal depression. The mood interview revealed the resident had feelings of being down, depressed, or hopeless, and had trouble falling or staying asleep, or sleeping too much on 1 day or less. The resident received a hypnotic medication during the 7-day observation period.

The Annual MDS dated 9/2/15, revealed the resident had a BIMS score of 15, indicating intact cognition. The resident's mood interview scored a 1, which revealed minimal depression. The resident received a hypnotic medication during the 7-day observation period.

The Psychotropic Drug Use CAA (care area assessment) dated 9/10/15 revealed the resident received a hypnotic medication. The CAA indicated when staff attempted a reduction in some of his/her medications, the resident became easily angered and irritated. The resident received the hypnotic as a sleep aide. The resident was alert and oriented, and could make his/her own decisions. The CAAs lacked documentation for the psychosocial, mood state, or behavioral symptoms for the resident.

The care plan, reviewed on 6/2/15, instructed staff if the resident could not fall asleep, staff were to encourage him/her to watch television to help relax, provide food or drink, and keep the head of the bed elevated.

Review of the physician's orders included and

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order dated 3/21/15 for Temazepam (Restoril- a hypnotic medication) 30 mg (mlligrams) daily for depressive disorder., and Risperidone (Risperdal) (antipsychotic medication), 0.25 mg, po (by mouth), 2 times daily, for psychosis.

Review of the assessments from 3/1/15-9/30/15 on the electronic record revealed the record lacked a hypnotic or sleep assessment for resident #31.

The resident's " Focused on High Risk Medications for the Elderly " form, dated 6/8/15, included these medications for physician review: Risperdal 0.25 mg and Temazepam 30 mg. The form documented the medications presented a potential risks for the resident. The form indicated if the resident should continue to receive the medications, the physician should mark the box with " No, Continue, and then indicate the reasons why so the records could be updated " . The physician documented to continue " for the resident's diagnoses. " However, the form lacked the physician's assessment of factors related to a risks versus benefits statement to explain the reasoning for the continued use of these medications for the resident.

On 9/30/15 at 8:18 AM licensed nursing staff K stated staff administered the Restoril for insomnia (an inability to fall asleep and stay asleep). At 2:51 PM, staff K stated the resident had a problem with sleep, and that the resident did not have a regular sleep pattern. Staff K also verified the facility failed to complete a sleep assessment for the resident.

On 9/30/15 at 3:29 PM, administrative nursing

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F 428	Continued From page 74 staff C, stated Restoril was not generally given for depressive disorder, and stated the resident did have difficulty with sleeping. Administrative nursing staff C stated no sleep assessments or sleep programs were completed or developed for resident #31. On 10/1/15 at 2:01 PM, the pharmacist was unavailable for an interview. The 3/9/15 consulting review indicated that all the medications had appropriate diagnosis. Review of a Medication Administration policy dated 3/2009 revealed medication administration would be done in a safe and orderly manner. The pharmacist failed to ensure the pharmacist identified irregularities in the monthly pharmacist review.	F 428		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441		

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(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 38 residents. Based on observation, interview and record review, the facility failed to maintain an infection control program to prevent, recognize and control to the extent possible the onset and spread of infection within the facility with the failure to trend infections and antibiotic use, failure to properly sanitize the glucometer, and failure to ensure staff changed oxygen tubing as expected to prevent the spread of infection, for the residents of the facility.

Findings included:

- Observation, on 9-29-15 at 10:05 am, revealed licensed nursing staff F obtained a blood glucose

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sample from an unsampled resident. After completion of the test, staff F then wiped the glucometer with an alcohol swab and proceeded to another unsampled resident's room and obtained a blood glucose sample. Staff F stated the policy was to use bleach to sanitize the glucometer, but thought alcohol wipes were effective.

Interview, on 9-29-15 at 10:30 am, with licensed nursing staff S, revealed the glucometer should be wiped off with a Sani wipe to sanitize it and stated 5 residents used this glucometer.

Interview, on 9-30-15 at 8:10 pm, with administrative nursing staff N, revealed staff should use the Sani wipes to sanitize the glucometer.

The facility policy for sanitizing the glucometer, dated 12-4-12, from the glucometer manufacturer, advised staff to clean the external surfaces with a bleach germicidal wipe.

The facility failed to sanitize the glucometer as directed by the manufacturer, to prevent the spread of infection among the 5 residents that use this glucometer.

- Interview on 9-30-15 at 11:30 am, with nursing staff E, revealed the tracking of infections in the facility was by culture results, and antibiotic usage. Staff E stated he/she did not monitor infections without cultures, or those with normal flora. Staff E stated he/she did not monitor for resolution of the infection unless another culture was obtained. Staff E stated the nursing staff filled in a log of all residents on an antibiotic, and

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he/she analyzed the data at the end of the month. Staff E stated there were no trends identified from May, 2015 through August, 2015.

Review of the logs from the nursing units, revealed:

Seven (UTIs)urinary tract infections in August, 2015.
Nine UTIs in July, 2015.
Eight UTI in June, 2015.
Five UTIs in May, 2015.
Five UTIs in April, 2015.
Six UTIs in March, 2015.
Two UTIs in February, 2015.
Two UTIs in January, 2015.
Four UTIs in December, 2014.

Interview, on 9-30-15 at 3:00 pm, with administrative nursing staff C, revealed the facility did have chronic urinary tract infections, chronic antibiotic use, and acute urinary tract infections, but did not identify trends as the log filled in by nursing staff did not identify the antibiotic use.

Interview, on 9-30-15 at 3:15 pm, with administrative nursing staff M, revealed he/she did not recall any trends identified prior to May 2015.

The facility lacked a policy for tracking and trending infections.

The facility failed to maintain and infection control program to prevent, recognize and control to the extent possible the onset and spread of infection within the facility by failing to trend infections and antibiotic use of the residents of the facility.

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F 441	Continued From page 78 - Observation, on 9-28-15 at 10:14 am, revealed oxygen tubing, dated 3-1-15, attached to an oxygen concentrator in resident # 21's room. Interview with the resident revealed the resident did not use the oxygen often, but thought he/she had used it a few nights ago. Observation, on 9-29-15 at 8:45 am, revealed resident #13's oxygen tubing attached to the oxygen outlet, and dated 5-15-15. Interview, on 9-29-15 at 8:50 am, with licensed nursing staff F, revealed the oxygen tubing should be changed every 30 days by the night nurse. Interview, on 9-29-15 at 6:15 pm, with licensed nursing staff W, revealed the night charge nurse changed the oxygen tubing on the first of each month, and should date the tubing. Interview, on 9-30-15 at 8:10 pm, with administrative nursing staff C, revealed he/she expected staff to change the oxygen tubing every 30 days. The facility lacked a policy for changing the oxygen tubing. The facility failed to change the resident's oxygen tubing, as expected, every 30 days, to ensure these at risk residents remained as free from infections as possible.	F 441		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520		

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A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.

The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.

A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.

Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 38 residents. Based on observation, interview, and record review the facility failed to maintain a quality assurance committee that developed and implemented appropriate plans of action to correct identified infractions of quality of care concerns for all the residents. In addition, the quality assurance committee failed to meet quarterly as required.

- Findings included:

- Review of the quality assurance committee

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attendance sheets, revealed the committee for the facility with the required facility members met on August 18, 2014, February 13, 2014, and September 28, 2014.

Interview, on 9-30-15 at 4:10 pm, with administrative nursing staff N, revealed the quality assurance committee met monthly but the meetings did not include 3 staff from the nursing facility, so it did not include the required committee members from the facility.

Furthermore, the facility's governing body failed to manage the facility in a manner to meet the needs of the residents as evidenced by this resurvey, including:

1) Failure to provide quality of care for the residents as evidenced by the following:

a) Refer to 309. The facility failed to monitor a bruise for 1 (# 31) of the 3 samples residents.

b) Refer to 311. The facility failed to review and revise the plan of care for grooming and bathing for 1 (#26) of the 16 residents reviewed.

c) Refer to 312. The facility failed to provide adequate assistance with personal hygiene needs for 2 of the 3 sampled residents, including; #22 with facial shaving and #33 with oral hygiene needs.

d) Refer to 315. The facility failed to ensure staff provided appropriate assessment and interventions to ensure 1 of 2 residents reviewed

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for urinary incontinence maintained as much normal bladder function as possible. This failure resulted in a decline in bladder continence for resident #2.

e) Refer to 323. The facility failed to ensure the residents ' environment remained as free of accident hazards as possible by the failure to ensure the exit doors had a functioning system to prevent cognitively impaired, independently mobile residents from wandering outside of the facility. Per facility reported 13 residents who were cognitively impaired and independently mobile.

f) Refer to 325. The facility failed to provide nutritional services for 2 (#36 and #37), of 3 residents reviewed for weight loss, to prevent weight loss.

g) Refer to 329. The facility failed to ensure 2 of 5 residents reviewed for unnecessary medications received adequate monitoring for antihypertensive medications, monitoring for PRN (as needed) medications (#25 and #31), and adequate justification of use (#31).

h) Refer to 333. The facility failed to ensure 1 of 5 residents reviewed for unnecessary medications were free of significant medication errors. (#28)

The facility's quality assurance committee failed

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F 520	Continued From page 82 to adequately address and implement a program to meet these identified residents' needs.	F 520		